

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17261**
Registrar's No. **18**

Registration District No. **275**

Primary Registration District No. **4016**

1. PLACE OF DEATH:

(a) County **Atchison**
(b) City or town **Tarkio**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **--**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **--** (Specify whether)
In this community **35yrs**
years, months or days)

3. (a) PRINT FULL NAME **DELPHIA MAY REYNOLDS**

3. (b) If veteran, name war **--** 3. (c) Social Security **500-07-3763**

4. Sex **female** 5. Color or race **q** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **Elmer R. Reynolds** 6. (c) Age of husband or wife if alive **--** years
7. Birth date of deceased **Dec 13 1901**
(Month) (Day) (Year)

8. AGE: Years **41** Months **4** Days **22** If less than one day
hr. min.

9. Birthplace **Norwood Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **House work**

11. Industry or business

12. Name **James N. Walker**
13. Birthplace **Tenn**
(City, town, or county) (State or foreign country)
14. Maiden name **Helen Kirkendal**
15. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Forest Mc. Ginnis**
(b) Address **Tarkio, Mo.**

17. (a) **burial** (b) Date thereof **5-7-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Tarkio Home Cemetery**

18. (a) Signature of funeral director **Davis Funeral Home**
(b) Address **Tarkio, Mo.**

19. (a) **May 11 1943** (b) **Mrs. R. D. Cunningham**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Atchison**
(c) City or town **Tarkio**
(If outside city or town limits, write "RURAL")
(d) Street No. **--** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **--**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5**
year **1943** hour **--** minute **5:45a** M.

21. I hereby certify that I attended the deceased from **3**
15 19**43** to **May 5** 19**43**
that I last saw her alive on **May 4** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of liver with metastasis** Duration **3 mos.**

Due to **46 f**

Due to **46 f**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Hard nodules in liver & spleen**
Of operations **--**
Of autopsy **--**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **--**
(b) Date of occurrence **--**
(c) Where did injury occur? **--** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **--** (Specify type of place) (e) Means of injury **--**

23. Signature **H. C. Bauman** (M. D. or other) **248**
Address **Glair, Mo** Date signed **5/7/43**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. **2394**

P. O. Address **Tarkio, Mo.**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17261Registration District No. 5Primary Registration District No. 4016Registrar's No. 18

1. PLACE OF DEATH:

- (a) County Atchison
 (b) City or town Garber
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether

In this community
years, months or days)3. (a) PRINT FULL NAME Delphina May Reynolds

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 12 1900
 (Month) (Day) (Year)

8. AGE: Years 41 Months 4 Days no (less than one day) min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

- (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (Date received local registrar) (b) Miss Mary Reynolds (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
 (c) City or town (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1943 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 19...
 that I last saw him alive on 19...
 and that death occurred on the date and hour stated above.
 Immediate cause of death

Duration

- Due to...

- Due to...

- Other conditions
 (Include pregnancy within 3 months of death)

- Major findings:
 Of operations

- Of autopsy

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)

- (b) Date of occurrence

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

- Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

